REPORT ON THE MARYLAND HEALTH CARE COMMISSION USER FEE ASSESSMENT

I. INTRODUCTION

Section 12 of Chapter 702 of the Annotated Code of Maryland, 1999 (House Bill 995) required the Commission to study and make recommendations on the appropriate funding level for the Commission and user fee allocation among those currently assessed. Initially, this report was due to the General Assembly in September 2000. The Commission requested and was granted a delay until December 30 to allow sufficient time for several new projects that the Commission has been mandated to implement to be developed so that accurate projections of the costs could be made. This report is intended to fulfill the statutory requirement under Section 12.

II. BACKGROUND ON ASSESSMENT MECHANISM

Chapter 702 "Health Regulatory Reform – Commission Consolidation" provided for the merger of the Health Resources Planning Commission (HRPC) and the Health Care Access and Cost Commission (HCACC) into a new entity the Maryland Health Care Commission (MHCC). The budget cap specified for the combined new commission of $8.25 million constituted the sum of the budget caps of the two predecessor commissions (HRPC - $3.25 million and HCACC - $5 million).The new Commission's funding is entirely user fee based, as were its predecessors. HRPC was funded through an assessment on hospitals and nursing homes while HCACC was funded through an assessment on health care practitioners and payers. The new allocation of funds among users was derived strictly from a proportional reallocation of each user group's contribution to the total combined MHCC budget.

Currently, the Commission assesses: 1) Payers for an amount not to exceed 40% of the total budget; 2) Hospitals and Special Hospitals for an amount not to exceed 36% of the total budget; 3) The Health Occupational Boards for an amount not to exceed 19% of the total budget; and 4) Nursing Homes for an amount not to exceed 5% of the total budget. The amount of an individual entity's assessment is derived differently for each group assessed.[1]

- Payers are assessed a fee in a manner that apportions the total amount assessed to be based on a ratio of each payer's total premium collected in the state for health benefit plans to the total collected premiums of all payers in the state;

- Hospitals are assessed the amount equal to one-half of the total fees to be assessed on hospitals times the ratio of admissions of the hospital to total admissions of all hospitals; and the amount equal to one-half of the total fees to be assessed on hospitals times the ratio of gross operating revenue of each hospital to total gross operating revenues of all hospitals;

[1] Health-General Article, Section 19-111, Annotated Code of Maryland.

- Nursing Homes are assessed the amount equal to one-half of the total fees to be assessed on nursing homes times the ratio of admissions of the nursing home to total admissions of all nursing homes; and the amount equal to one-half of the total fees to be assessed on nursing homes times the ratio of gross operating revenue of each nursing home to total gross operating revenues of all nursing homes; and

- Health Occupational Boards are assessed a fee that apportions the total amount assessed based on number of licensees for each board assessed. The Commission currently collects the practitioner assessment from chiropractors, dieticians/nutritionists, occupational therapists, physical therapists, podiatrist, clinical social workers, speech/language pathologists, physicians, advance practice nurses, pharmacists, and psychologists. Determination of what practitioner boards would be assessed was based on those practitioners who could bill independently or those who perform health care services that are reported to the Commission's statewide database.

III. LEVEL OF FUNDING

When the former Health Care Access and Cost Commission and the former Health Resources Planning Commission were merged under Chapter 702 (1999), the budgets of the two Commissions were simply added to arrive at the user fee cap. It was assumed, at the time, that the merger would result in significant cost reductions. These savings have not occurred, as there has not been significant reduction in the statutory responsibilities of the merged Commission. A July 2000 report on the merger made to the General Assembly noted, "the consolidation resulted in a reduction of administrative costs of about $400,000."[2] The majority of this reduction resulted from the transfer of local health planning to Department of Health and Mental Hygiene.

During the same year as the merger (1999), legislation was passed requiring HCACC (now MHCC) to develop performance reports for nursing homes, hospitals, and ambulatory surgical facilities by July 2001. Funds for developing these projects activities were included in the fiscal note on the hospital and ambulatory surgical facility performance evaluation reports. Funds were not included for the nursing home performance report since the reporting requirement was amended into a bill on Sine Die and did not go through a departmental review. As the time approaches to actually produce these new performance reports, the Commission faces the dilemma of exceeding its budget cap to comply with the reporting requirements or adhering to the budget cap and failing to produce the required consumer reports. Many of the elements of performance reporting required by statute such as measures of patient satisfaction are expensive to collect in a reliable and valid manner due to the unique nature of the population to be surveyed and the large number of entities to be evaluated. Moreover, the legislature has also expressed an interest in the Commission developing measures to assess the quality of behavioral health care delivered by managed behavioral health care organizations and obtaining more accurate detailed estimated of the uninsured population in the State. In addition, under House Bill 649 (2000), the Commission was required to study the effect of group size on the small group market. The results of that survey indicate that the data being reported to the Commission by the carriers is

[2] Required Under Chapter 702 (1999) – "Health Care Regulatory Reform – Commission Consolidation," Final Report on the Potential Merger of the Health Services Cost Review Commission and the Maryland Health Care Commission, July 1, 2000.

inadequate. The Commission is recommending the possible auditing of carrier data submission to assure premiums remain under the small group market affordability cap. Finally, the Commission is seeking to develop a Cardiac Database. Raising the user fee cap will allow the flexibility to comply with current and future statutory mandates.

The Commission voted unanimously to recommend that legislation be introduced during the 2001 legislative session to raise the user fee cap from $8.25 million to $10 million. It is anticipated that this increase of $1.75 million will allow for the growth needed in the Commission budget to carry out tasks that are currently required and not yet fully implemented as well as future mandates. This increase would be introduced incrementally over a minimum of 5 years. At this rate, the increase is only 4% annually, and is below the allowable standard for inflationary growth. Without this increase in the user cap, the Commission will not have sufficient funds to meet all its required activities.

IV. ALLOCATION OF COSTS

The Commission's budget is prepared by the distribution of costs to four divisions. These divisions are separated by Project Coding Appropriation codes and are: 1) Executive Direction – incorporates all administrative costs/salaries needed to operate the Commission on a daily basis; 2) Data Systems and Analysis – incorporates all costs for Data Base Applications Development, Cost and Quality Analysis, and EDI Programs and Payer Compliance; 3) Performance and Benefits – incorporates all costs for Benefit Analysis, Legislative and Special Projects, and HMO Quality and Performance; and 4) Health Resources – incorporates all costs for Acute and Ambulatory Care, Long Term Care and Mental Health Services, Specialized Health Care Services, and Certificate of Need.

In the process of researching expenditures and how they should be allocated among the entities that are assessed, the staff examined statutory requirements set forth for each division and the projects associated with them. Three of these divisions have very defined projects both in scope and with respect to whom the targeted audience is, which made allocation of those costs straightforward (Summary Workload Analysis 1, 2, and 3). The exception was the Executive Division.

The Executive Division's budget consists of the salaries of the Executive Director, the administrative staff, all other adjustments to salaries for the entire Commission, but most importantly, all residual costs associated with overall operations. Therefore, expenditures associated with this division are the most difficult to allocate (Summary Worksheet 4).

OPTIONS FOR USER FEE ALLOCATION

The FY 2001 budget allowance is $7,786,524. Since $5,872,821 can be attributed to specific projects and their users, this left $1,913,703 in residual costs for allocation. Staff explored several options to distribute these residual costs. Outlined below are the status quo, as a basis for comparison, and four options for distribution of the residual. It should be noted that both Options 2 and 4 are more radical in that they assume that user fees will be totally reallocated based on the

workload analysis. Options 3 and 5 are more modest calling for the reallocation to occur incrementally.

- OPTION 1 – Status Quo

Option 1 illustrates the current total assessment by each payer group, the percentage assessed, and the dollar equivalent for FY 2001, as required by Chapter 702 (1999).

- OPTION 2 – Equal Distribution of Residual

Option 2 separates the residual from the portion of the budget that is attributed to each payer class, evenly distributes the residual by 25% or $478,426 to each user group, and then adds this amount to their portion of the budget. The total is then the new percentage assessed. Option 2 also compares the new percentage to the current percentage and illustrates the percentage increase or decrease. The Option 2 assessment would be: Payers - 35%; Nursing Homes - 21%; Hospitals - 21%; and Boards - 23%. Payer and hospital assessments would decline by 5% and 15%, respectively, while nursing home and board assessments would increase by 15% and 4%, respectively.

- OPTION 3 – The Midpoint between Status Quo and Option 2

Option 3 indicates a reallocation of fees at a percentage that is a midpoint between the Status Quo and Option 2, a reallocation based on total workload distribution. Staff explored the option of increasing or decreasing the Option 2 workload reallocation by one-half rather than the full amount to reduce the disruption in any user fee group's assessment. Under this model, instead of increasing the nursing home assessment by 16% and reducing the hospital assessment by 15%, the increase would be 8% and the decrease 7.5%, respectively. Assessments would be: Payers - 37.5%; Nursing Homes - 13%; Hospitals - 28.5%; and Boards - 21%.

- OPTION 4 – Proportional Distribution of Residual by Allocation of Maryland's Health Care Expenditures

Option 4 distributes the residual proportionally by allocation of Maryland's Health Care Expenditures. According to 1998 data analyzed by the Commission in its State Health Care Expenditures Chartbook [3], Inpatient Hospital and Outpatient Hospital services are responsible for 34% of Maryland's health care expenditures, Health Occupational Boards 37%, and Nursing Homes 7.4%. The remaining 22% was allocated to Payers.[4] Under this scenario, assessments would be: Payers - 34%; Nursing Homes - 7%; Hospitals - 23%; and Boards - 26%.

- OPTION 5 – Midpoint between Status Quo and Option 4

Option 5 displays user fee allocations as the midpoint between the Status Quo and Option 4. Since the Nursing Home assessment would be increased by 12% and the hospital assessment

[3] Maryland Health Care Commission, State Health Care Expenditures Chartbook 1998, Released March 2000.

[4] The hospital, nursing home, and practitioner expenditures, as part of the health care dollar, are additive. The payer's portion represents the difference between the 100% and the other user's expenditures.

would be reduced by 13% under Option 4, Option 5 would increase or decrease the differences by only one-half to affect a more modest shift in allocation. Under this option, assessments are: Payers - 37%; Nursing Homes - 11%; Hospitals - 29.5%; and Boards - 22.5%.

V. PUBLIC COMMENT AND STAFF RECOMMENDATIONS

Staff presented these options to the Commission at its November 2000 meeting. After reviewing the user fee allocation options, the staff recommended that the Commission adopt either one of the two more modest reallocations of the user fee: either Option 3 or Option 5. The percentage increase for nursing homes in Option 2 and 4 is a drastic change to be implemented in one fiscal year and could be disruptive to the marketplace. Both Option 3 and Option 5 are midpoints and pose no major disruption in any one sector and provide the most stability for the Commission and those who pay the user fee.

The draft was available for a period of public comment until December 5th, 2000. The Commission received public comments from the Board of Examiners for Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists; The Speech-Language Hearing Association; The Health Facilities Association of Maryland (HFAM); and the Association of Maryland Hospitals and Health Systems (MHA).

The Board of Examiners commented favorably on the percentage increase from the current 19% to 21-22.5% as proposed in Option 3 and 5, recognizing the Commission's increased legislative mandates, but the expressed concern about several classes of health care practitioners who are not assessed. The Board requested that the Commission reexamine this issue; staff will do so during 2001.

The Speech-Language and Hearing Association commented on the requested increase in the Commission's user fee cap from $8.25 million to $10 million and requested a listing of the additional tasks that warrant this increase, which the staff provided. The Association also expressed a concern about the practitioners not assessed.

Comments were received from the MHA objecting to the proposal to increase the user fees by $1.75 million. Another point of concern was that the additional responsibilities that are the basis for this increase should be assessed proportionately. Proportional assessment is the basis for the staff analysis and recommendations.

Finally, comments were received from HFAM in favor of staff recommendations of Option 3 or 5 for reallocation of the user fee percentages. However, their request was for a two-year phase-in under which nursing home fees would increase by only 8% each year. HFAM was also in agreement with the proposal to promulgate the user fee allocation through regulation rather than statute and to review the assessment formula in four (4) year intervals.

Staff has concluded that a phase in of this increase for nursing homes over a two-year period is not favorable to the other user groups that would ultimately pay a lesser apportionment because of this increase. Both Options 3 and 5 were recommended to accomplish this increase to the Nursing Homes incrementally.

Staff reviewed public comment and recommended that the Commission support Option 3, the equal distribution of the residual. This option to equally divide the residual among users and assess the midpoint between the current percentage and the revised percentage distribution is straightforward in its calculation and is easily understood.

VI. RECOMMENDATIONS

At its December 2000 meeting, the Commission unanimously approved the following recommendations:

1. To allow the Commission to implement current performance reporting requirements, and to accommodate future legislative requests and cost-of-living increases, raise the user fee cap by $1.75 million to a total of $10 million. The merger of HCACC and HRPC did not produce the anticipated savings since tasks have not been reduced. Moreover, the MHCC has been charged with several complex duties that are costly to implement if they are to be reliable and valid comparative evaluations. The Commission estimates that this increase would be implemented over the next 5 years, at a minimum.

2. To promote stability in the assessment process, keep any assessment formula in place for a period of four years. This would allow those health occupational boards that assess biannually to complete two assessments cycles.

3. To allow flexibility in reapportioning the allocation among users, remove specific percentages from statute and promulgate them in regulation. This would permit periodic (4-year) evaluations of workload distribution without a change in statutory law while allowing for continuing legislative and public oversight.

4. Option 3 for redistributing the use fee assessment should be adopted. Under Option 3, which assumes the residual administrative costs are equally distributed among users, the percentages for assessment would be as follows: payers - 37.5%; nursing homes - 13%; hospitals - 28.5%; and practitioner boards - 21%. This option allows for the least disruption to any sector of the user fee group and can be calculated and understood with ease.